PRINTED: 05/14/2009

BERNADETTE CARE HOME		1104 IRONWOOD DRIVE LAS VEGAS, NV 89108				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 000	Initial Comments		Y 000			
	The findings and conclusions of any investig by the Health Division shall not be construct prohibiting any criminal or civil investigations actions or other claims for relief that may be available to any party under applicable feder state, or local laws.	d as				
	This Statement of Deficiencies was generated a result of an annual State Licensure survey conducted in your facility on May 7, 2009. The State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Helpivision.	, ⁻his ne				
	The facility is licensed for nine Residential F for Group beds which provide care for person with Alzheimer's disease, Category II resident The census at the time of the survey was nin Nine resident files were reviewed and four employee files were reviewed. One dischart resident file was reviewed. The facility recein grade of D.	ons nts. ne.				
	The following deficiencies were identified:					
Y 105 SS=F	449.200(1)(f) Personnel File - Background C	Check	Y 105			
	NAC 449.200 1. Except as otherwise provided in subsection a separate personnel file must be kept for earnember of the staff of a facility and must incomplete (f) Evidence of compliance with NRS 449.17449.185, inclusive.	ach clude:				
	This Regulation is not met as evidenced by Based on record review on 5/7/09, the facilit failed to ensure 2 of 4 caregivers met backg	:y				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
NVS75AGZ NAME OF PROVIDER OR SUPPLIER BERNADETTE CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1104 IRONWOOD DRIVE LAS VEGAS, NV 89108					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE			
Y 105	check requirements Severity: 2	(Employee #3 and #4). Scope: 3		Y 105				
Y 176 SS=F	Rodents NAC 449.209			Y 176				
	Based on observation to keep the cupboard below the	not met as evidenced by on on 5/7/09, the facility rds under the kitchen sin stove, cupboard to the lathe second drawer next in mice droppings. Scope: 3	failed k, the eft of					
Y 178 SS=B	NAC 449.209 5. The administrator ensure that the prer	nd Sanitation-Maintain I of a residential facility s nises are clean and that I landscaping of the facil	shall the	Y 178				
		not met as evidenced by view, the administrator d						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED				
REPNADETTE CAPE HOME			1104 IRONV	D5/07/2009 REET ADDRESS, CITY, STATE, ZIP CODE 104 IRONWOOD DRIVE AS VEGAS, NV 89108					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	E ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE				
Y 178 Y 250	(broken shower doo immobile closet doo Severity: 1 Se	cility was well maintaine r pane in bathroom #1 a	nd	Y 178 Y 250					
SS=F	NAC 449.217 1. The equipment in a kitchen of a residential facility and the size of the kitchen must be adequate for the number of residents in the facility. The kitchen and the equipment must be clean and must allow for the sanitary preparation of food. The equipment must be in good working condition.		st be ration						
	Based on observation the food preparation for the sanitary prepand debris on the strovens and surround	not met as evidenced by on and interview on 5/7/0 area was not clean allo aration of food (dust, grovetop, ventilation covering areas).	09, wing ease						
Y 252 SS=C	449.217(3) Storage Packaging	of Food-Adequate stora	ge;	Y 252					
	and equipment used	must be available for al I for cooking and storing nust be appropriately							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED				
		NVS75AGZ				05/0	7/2009		
REPNADETTE CAPE HOME 1104 IRON			1104 IRON	DRESS, CITY, STATE, ZIP CODE NWOOD DRIVE AS, NV 89108					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	CTION SHOULD BE COMPLE O THE APPROPRIATE DATE			
Y 252	Continued From page 3			Y 252					
Y 444 SS=F	Based on observation stored in the garage of bag. The opening of which allowed for accessive to the second severity: 1 Scott 1	nust be maintained in p at all times and must be results of the tests purs st be recorded and	eing nal er ts. oroper e	Y 444					
	Based on record reviews 5/7/09, the facility did detectors functioned test smoke detectors	ot met as evidenced by ew and observation on not ensure all smoke and that staff knew how ficiency from the 12/19	v to						
	survey.								
	Severity: 2 S	cope: 3							
Y 908 SS=B	449.2746(2)(a)-(f) PF	RN Medication Record		Y 908					
	NAC 449.2746								
	2. A caregiver who as	dministers							

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not ensure the medication record was complete for 2 of 9 residents receiving as needed (PRN) medications (Resident #5 and #6).

Severity: 1 Scope: 2

Y 920 SS=F 449.2748(1) Medication Storage

NAC 449.2748

1. Medication, including, without limitation, any

over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized Y 920

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

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If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

This Regulation is not met as evidenced by: Based on observation on 5/7/09, drawers in the kitchen were left unlocked and contained knives and a lighter which were accessible to 8 of 9

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS75AGZ** 05/07/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1104 IRONWOOD DRIVE **BERNADETTE CARE HOME** LAS VEGAS, NV 89108 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 994 Continued From page 6 Y 994 residents. Severity: 2 Scope: Y 999 Y 999 449.2754(1)(g) Alzheimer's Facility SS=F NAC 449.2756 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that: (g) All toxic substances are not accessible to the residents of the facility. This Regulation is not met as evidenced by: Based on observation on 5/7/09, the administrator failed to ensure that toxic substances were not available to residents (insect poison spray under the sink in an unlocked cabinet). Severity: 2 Scope: 3